GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH PROFESSIONAL LICENSING ADMINISTRATION
BOARD OF MEDICINE
NEW LICENSE APPLICATION FOR MEDICINE & OSTEOPATHY

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to DC Code 22-2514. If you have any questions, call HPLA Customer Service at **1-888-204-6193**, Monday through Friday, 8AM to 5PM EST.

SECTION 1A. TYPE OF LICENSE

Check the box next to the type of license for which you are applying. ☐ Medicine and Surgery (MD) ☐ Osteopathy and Surgery (DO)

SECTION 1B. BASIS OF APPLICATION

Check the box next to the basis by which you are applying. ***Do not select "EXAMINATION" if you have already passed the USMLE Step III Examination**

	TOTAL
☐ Examination	$288
☐ Re-examination	$ 85
☐ Waiver of Examination – USMLE	$805
☐ Waiver of Examination – NBME/NBOME/LMCC	$805
☐ Waiver of Examination – FLEX	$805
☐ Waiver of Examination – State Constructed Exam	$805
☐ Waiver of Examination – Combination of Above	$805
☐ Eminence 1	$805
☐ Eminence 2	$2000
☐ **Duplicate Licenses (limit 5)** _____ **X $34.00 =**	**$_____.00**
Total Enclosed	**$_____.00**

Make check or money order payable to **DC Treasurer**.
A charge of $65.00 will be imposed for dishonored checks (Public Law 89-208)

MAIL TO:
Department of Health
Health Professional Licensing Administration
Board of Medicine
717 – 14th St, NW
Suite 600
Washington, DC 20005

HPLA ONLY

Check $	Check #	Staff
$ __ __ __ .00		

SECTION 2. APPLICANT NAME/DEMOGRAPHIC INFORMATION

Enter your name exactly as it should appear on the license. If your name has changed at any point since you first attended college or university, you must provide a copy of legal name change document for EACH time that it has changed. Acceptable documents are marriage certificates, divorce decrees or court orders. Complete Section 4 below of this application on page 2.

FIRST NAME | MI | LAST NAME | SUFFIX (e.g. "Jr.", "Sr." not "M.D.")

SOCIAL SECURITY NUMBER*
If applicant does not provide a social security number, a sworn affidavit is required.

M M – D D – Y Y Y Y
DATE OF BIRTH

PLACE OF BIRTH
Provide City and State for US birthplace or Country for foreign place of birth.

☐ Male ☐ Female
GENDER
Please check the correct box.

SECTION 3A. HOME ADDRESS

A PO Box may not be used for an address. Please provide a street address.

☐ APARTMENT ☐ SUITE ☐ FLOOR NUMBER

HOME STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise, use this line to indicate STREET NUMBER and STREET NAME)

HOME STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

STATE | ZIP CODE + 4

HOME PHONE NUMBER | HOME FAX NUMBER | E-MAIL ADDRESS

* Under the authority of Public Law 93-579, Section 7 (b), the Department of Health requests your Social Security Number to assist in the administration of D.C. tax laws. Disclosure is not required as a part of the licensing process and will not be made available to the public.

SECTION 3B. BUSINESS ADDRESS

A PO Box may not be used for an address. Please provide a street address. **Please note: This information will be made available to the public.**

COMPANY NAME

☐ APARTMENT ☐ SUITE ☐ FLOOR NUMBER

BUSINESS STREET ADDRESS 1 (If applicable, use this line for additional building information. Otherwise use this line to indicate STREET NUMBER and STREET NAME)

BUSINESS STREET ADDRESS 2 (If additional space is needed, use this line to indicate STREET NUMBER and STREET NAME)

CITY

STATE ZIP CODE + 4

BUSINESS PHONE NUMBER BUSINESS FAX NUMBER E-MAIL ADDRESS

SECTION 3C. PREFERRED MAILING ADDRESS

Indicate your preferred mailing address by placing an "X" in the appropriate box. This will be the address to which all future licensing documents will be mailed. The address that will appear on your license will be your business address.

☐ HOME ☐ BUSINESS

SECTION 4. PREVIOUS NAME CHANGE

If your name has changed at any point since you first registered with the American Medical Association, taken any exams or attended college or university, you must provide a copy of a legal name change documents for EACH time that it has changed. Acceptable documents for individuals are marriage certificates, divorce decrees, or court orders.

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate

FIRST NAME MI LAST NAME SUFFIX

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate (e.g. "Jr.", "Sr." not "M.D.")

FIRST NAME MI LAST NAME SUFFIX

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate (e.g. "Jr.", "Sr." not "M.D.")

FIRST NAME MI LAST NAME SUFFIX

Changed to current name by: ☐ Marriage ☐ Divorce ☐ Court Order ☐ Spouse Death Certificate (e.g. "Jr.", "Sr." not "M.D.")

SECTION 5. SUPPORTING DOCUMENTS

Please indicate the supporting documents you have included with this package or requested to be sent to the DC Board of Medicine. Keep a photocopy

		YES	NO	HPLA ONLY
A.	Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.	☐	☐	
B.	Three (3) characters reference forms.	☐	☐	☐
C.	AMA Profile.	☐	☐	☐
D.	Verification(s) of licensure – These should be provided in a sealed envelope from the issuing jurisdiction for each license identified in Section 6C.	☐	☐	☐
E.	All undergraduate, graduate, medical, and profession school transcripts. These transcripts should be provided in a sealed envelope from the issuing institution for each of the schools that you attended and listed in Section 6A on the previous page.	☐	☐	☐
F.	Documentation of all experience following graduation from medical school. Proof of experience should be submitted as a letter from the overseeing institution/organization.	☐	☐	☐
G.	Examination scores – These should be provided in a sealed envelope from the examination contractor or administrator.	☐	☐	☐
H.	ECFMG Certificate (if Foreign applicant)	☐	☐	☐

SECTION 5. SUPPORTING DOCUMENTS (CONT'D)

I.	FMGEMS Certificate (if Fifth Pathway applicant)	YES ☐ NO ☐	☐
J.	Eminence application package (if Eminence 1 or 2 applicant)	YES ☐ NO ☐	☐

SECTION 6A. POST SECONDARY SCHOOLS ATTENDED

List all colleges and universities attended prior to and including medical schools, in reverse chronological order, beginning with the most recent at the top.

School Name, City, State, Country		Date of Graduation	Type of Degree/Certificate

SECTION 6B. MEDICAL TRAINING AND MEDICAL PRACTICE – POSTGRADUATE EXPERIENCE

List **ALL** experience since medical school graduation below. Include letters (No Certificates) from employing facilities and organizations for internships, residencies, fellowships or employment. For "Description", use the letter key below. List experience in reverse chronological order, beginning with the most recent. Be sure to account for periods of unemployment greater than three (3) months. Please account for all time since medical school graduation.

Organization/Institution	Start Date	End Date	Type of Position (Use Key Below)*

* TYPE OF POSITION KEY / TRAINING AND PRACTICE DESCRIPTIONS

A. Fellowship
B. Internship
C. Residency
D. Employment
E. Private Practice
F. Other (Attach a typed explanation on a separate sheet of paper to this form.)

SECTION 6C. MEDICAL LICENSES IN OTHER STATES/JURISDICTIONS

List **all** states and jurisdictions in which you have ever held a license (excluding training licenses). Provide letters of verification from original and current jurisdictions (if different).

Jurisdiction	Date License Was First Obtained	License Number

SECTION 7. SCREENING QUESTIONS – Applicants MUST answer all of the following questions.

Please answer questions A through K by placing an "X" in the appropriate boxes. If you answer "Yes" to questions A through K below, you must provide full information and complete details **on a separate sheet of paper, including copies of all relevant court documents,** and attach to this form.

A.	**Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement.** Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your License or Permit** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001). IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR NEW LICENSE APPLICATION BE DENIED. As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following: Yes ☐ No ☐ 1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985); 2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994); 3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985); 4. Past due taxes; 5. Past due District of Columbia Water and Sewer Authority service fees; or 6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)? The information presented above is in compliance with the requirement to submit with your application for licensure or permit under the *Clean Hands Before Receiving a License or Permit Act of 1996*, effective May 11, 1996 (D.C. Law 11-118, D.C. Code §47-2861 et seq.).	YES ☐ NO ☐	**HPLA ONLY**
B.	Have you ever been convicted or investigated of a crime or misdemeanor (other than minor traffic violations) not previously reported to the Board?	YES ☐ NO ☐	☐
C.	Have you ever been party to a malpractice action or had a malpractice action brought against you?	YES ☐ NO ☐	☐
D.	Have you ever voluntarily surrendered a license after formal charges have been filed against you or while under investigation?	YES ☐ NO ☐	☐
E.	Has any authority taken adverse action against your medicine/osteopathy license or privileges or informed you of any pending charges not previously reported to this Board?	YES ☐ NO ☐	☐
F.	Have you ever surrendered your clinical privileges or had your clinical privileges denied, revoked or suspended at any hospital or health care facility?	YES ☐ NO ☐	☐
G.	Have you ever been terminated from or resigned from a clinical or professional training program?	YES ☐ NO ☐	☐
H.	Do you have a physical or medical condition that currently impairs your ability to practice your profession?	YES ☐ NO ☐	☐
I.	Within the last ten (10) years, have you been treated for alcohol abuse, controlled substance abuse, prescribed medication abuse, or illegal drug abuse?	YES ☐ NO ☐	☐
J.	(1) Have you withdrawn an application (in D.C. or any other state/jurisdiction) to practice your profession? (2) Has any authority or peer review board taken adverse action against your license or privileges? (3) Are you currently under investigation or were you investigated by any authority or peer review board for any violation of state, federal, or local law? (4) Has any authority or peer review board informed you of any pending charges(s) or investigation not previously reported to this Board?	YES ☐ NO ☐	☐
K.	Have you ever been terminated due to practice issues or moral turpitude issues since obtaining your (professional) license within the last ten (10) years?	YES ☐ NO ☐	☐
L.	MD's Only – If your practice is limited to a specialty, please indicate the code from the specialty listed below. **CODE**	☐☐	☐

M.	MD's Only – If you are certified by the "American Board of" any specialty, please indicate the code from the specialty list below. **CODE**	☐☐	☐

SPECIALTIES

AD Administrative Medicine	NE Neurological Surgery	PH Physical Medicine & Rehabilitation
AL Allergy & Immunology	NU Nuclear Medicine	PL Plastic Surgery
AN Anesthesiology	OB Obstetrics & Gynecology	PR Preventive Medicine/Public Health
CO Colon & Rectal Surgery	OP Ophthalmology	PS Psychiatry & Neurology
DE Dermatology	OR Orthopedic Surgery	RA Radiology
EM Emergency Medicine	OT Otolaryngology	SU Surgery
FA Family Practice	PA Pathology	TH Thoracic Surgery
IN Internal Medicine	PE Pediatrics	UR Urology
MG Medical Genetics		

SECTION 8. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

LICENSEE SIGNATURE	NAME (Please Print)	DATE	HPLA ONLY
_____	_____	_____	☐

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.